Dr. Maddux

MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027912 STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1136

FILED JUL 18 1963

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

1 0397
2 0391 2
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4 1
5 2
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7 1
8 2
9 9040
10 45
11 133
12 86.0
13

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY: GREENE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: SPRINGFIELD
Length of stay in 1b: 35 YRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: CONNELLY REST HOME
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: GREENE
c. CITY OR TOWN: SPRINGFIELD
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1019 W. ELM ARCADE
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First MINTIE Middle CURNUTT Last

4. DATE OF DEATH: Month JULY Day 12 Year 1963

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]
8. DATE OF BIRTH: 11/19/75
9. AGE (last birthday): 87
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): NEWTON, ARK.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: JAMES P. JONES
13b. MOTHER'S MAIDEN NAME: FREDONIA MASSENGALE
14. NAME OF HUSBAND OR WIFE: DANIEL C. CURNUTT (DEC)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
17. INFORMANT Address: BERT CURNUTT, SPRINGFIELD, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c): Intertrochanteric Fracture Right Femur
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Chronic Cystitis

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [X] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.): Fell at home 5-19-63 fracturing rt. hip
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: 5-19-63
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
20f. CITY, TOWN, OR LOCATION COUNTY STATE: Springfield, Missouri

21. I attended the deceased from 5-19-63, to 7-12-63 and last saw her alive on 7-11-63
Death occurred at 4:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): W. Bark, M.D.
22b. ADDRESS: 609 Cherry, Springfield Mo
22c. DATE SIGNED: 7/12/63

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 7/15/63
23c. NAME OF CEMETERY OR CREMATORY: GREENLAWN
23d. LOCATION (City, town, or county) (State): SPRINGFIELD, MO.

24. FUNERAL DIRECTOR ADDRESS: H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.
25. DATE RECD. BY LOCAL REG.: 7-15-63
26. REGISTRAR'S SIGNATURE: Effie B. Meeks

(Licensed Embalmer's Statement on Reverse Side)

Permit 7-12-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Lucian T. Shadley

Licensed Embalmer No. 4815

P. O. Address Lexington, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.